Women/Maternal Health

State Action Plan Table (Florida) - Women/Maternal Health - Entry 1

Priority Need

Improve access to health care for women to improve preconception and interconception health, specifically women who face significant barriers to better health.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

1. By December 31, 2021, increase the rate of female teens (13-17 years of age) who have completed the first dose of HPV vaccine from 57.2 percent (National Immunization Teen Survey: 2014) to 70 percent.

2. By December 31, 2021, decrease the number of syphilis cases among women ages 15-44 years from 1,011 (PRISM: 2016) to 859.

3. By December 31, 2021, increase percent of new mothers in Florida who received information about how to prepare for a healthy pregnancy and baby prior to pregnancy from 22.8 percent (FL-PRAMS: 2014) to 30 percent.

4. By December 31, 2020 increase the percentage of treatment started for Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP) eligible women diagnosed with cervical cancer or cervical precancer that initiate treatment from 50 percent in 2017 to 75 percent in 2020.

5. By Dec. 31, 2018, reduce the rate of late-stage (advanced stage) female breast cancer from 41.3 per 100,000 (2012) to 40.2 per 100,000.

6. By Dec. 31, 2018, reduce invasive cervical cancer from 8.4 per 100,000 (2012) to 8.0 per 100,000.

7. By December 31, 2021, increase the number of individuals at risk of type 2 diabetes participating in the CDC Recognized Diabetes Prevention programs from 4,340 (CDC-Diabetes Prevention Recognition Program Quarterly Report: 2016) to 10,000.

8. By December 31, 2021, increase the percentage of adults with hypertension served by Federally Qualified Health Centers who have their blood pressure adequately controlled (<140/90) from 60.6 percent (HRSA Health Center Program Grantee Data: 2015) to 72.7 percent.

Strategies

1. Collaborate with the Division of Disease Control and Health Protection/Bureau of Communicable Diseases to promote awareness and support community partnerships to increase access to immunizations, and to increase immunization rates for vaccine preventable diseases in Florida's teens through educational outreach events, vaccine distribution clinics, monitoring site visits, and media campaigns.

2. Collaborate with the Division of Disease Control and Health Protection/Bureau of Communicable Diseases to reduce the number of syphilis cases through provider and public awareness, enhanced surveillance, and expanded quality improvement activities.

3. Develop and/or identify an evidence-based interconception health curriculum for statewide implementation in the Healthy Start program.

4a. Collaborate with the Division of Community Health Promotion to help educate women regarding the importance of cervical cancer screening and on the importance of cervical cancer treatment.

4b. Collaborate with the Division of Community Health Promotion to help promote and identify community organizations that provide cervical cancer treatment to women who are not eligible for Medicaid services.

5. Collaborate with the Division of Community Health Promotion to help educate women who are eligible for the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP) and non-program eligible women on the importance of breast cancer screening through multiple avenues.

6. Collaborate with the Division of Community Health Promotion to help recruit women who meet FBCCEDP's criteria as well as non-program women, and educate them of importance of cervical cancer screening.

7. Collaborate with the Bureau of Chronic Disease Prevention to promote policy and systems change to healthcare providers to increase adherence to clinical best practices and national recommendations for chronic disease prevention and increase utilization of available resources.

8. Collaborate with the Bureau of Chronic Disease Prevention to promote policy and systems change to healthcare providers to increase team-based care and care coordination approaches for chronic disease treatment and management to ensure optimal and equitable care for all segments of the population.

ESMs	Status
ESM 1.1 - The number of interconception services provided to Healthy Start clients	Active

NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
NOM 5 - Percent of preterm births (<37 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Florida) - Women/Maternal Health - Entry 2

Priority Need

Promote tobacco cessation to reduce adverse birth outcomes and secondhand smoke exposure to children.

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

1. By December 31, 2021, increase the number of referrals to Tobacco Free Florida Quit Services from 20,533 (DOH-Tobacco-Free Florida Quit Line Providers: 2016) to 23,000.

2. By September 30, 2020, decrease the percentage of women who smoked cigarettes in the three months prior to becoming pregnant from 19.1 percent in 2014 (2014 PRAMS Report) to 16.6 percent.

Strategies

1. Collaborate with the Bureau of Tobacco Free Florida to promote pregnant women in the Healthy Start program to participate in the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) and refer to the Tobacco Free Florida Quit Line.

2a. Increase the number of health care providers who address the dangers of smoking and tobacco use in the preconception visit.

2b. Develop/update trainings on preconception health to include information about the dangers of tobacco.

2c. Increase the number of health care providers who utilize preconception health screening tools and resources to identify smokers.

ESMs	Status
ESM 14.1.1 - The number of Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) services provided to Healthy Start clients	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Perinatal/Infant Health

State Action Plan Table (Florida) - Perinatal/Infant Health - Entry 1
Priority Need
Promote breastfeeding to ensure better health for infants and children and reduce low food security.
NPM
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Objectives
1. By December 31, 2021, increase the number of Baby-Friendly Hospitals from 10 (2017) to 20.
2. By December 31, 2021, increase the number of breastfeeding-friendly work places from 111 (2017) to 220.
3. By December 31, 2021, increase the number of breastfeeding-friendly early care and education programs from 230 (2017) to 300.
4. By April 30, 2019, increase the number of very low birth weight infants in Florida's NICUs who receive at least 50 percent of their feedings as their mother's own milk at discharge from 45.7 percent (2013) to 68.6 percent.
Strategies
1a. Using the Florida Healthy Babies Initiative, develop a plan to encourage hospitals to establish policies and protocols in support of breastfeeding and becoming a Baby Steps to Baby Friendly hospital or a Florida Breastfeeding Coalition's Quest for Quality Maternity Care Award recipient.
1b. Support the Bureau of Chronic Disease in their efforts to provide technical assistance to hospitals, work places, and early care and education program to implement breastfeeding policies and programs by partnering with the Florida Breastfeeding Coalition and the Florida Child Care Food Program.
2. Support the breastfeeding/pumping in the Department's workplace policy.
3. Improve access to breastfeeding support for Healthy Start clients not eligible for WIC.
4a. Contract with the FPQC to implement the Mothers Own Milk (MOM) hospital-based quality improvement initiative that promotes evidence-based interventions to increase the use of breast milk for VLBW infants in the NICU.
4b. Support the FPQC with helping hospitals participating in the MOM Initiative to implement key practice interventions.
4c. Support the FPQC in monitoring outcome measures from hospitals participating in the MOM Initiative.

ESMs	Status
ESM 4.1 - The number of Florida hospitals achieving the Baby Steps to Baby Friendly hospital designation.	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Florida) - Perinatal/Infant Health - Entry 2

Priority Need

Promote safe and healthy infant sleep behaviors and environments, including improving support systems and the daily living conditions that make safe sleep practices challenging.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

1. By December 31, 2021 reduce percent of black mothers in Florida whose infant sleeps in bed with a parent or anyone else from 26.4 percent (2014) to 24.8 percent.

2. By December 31, 2021, increase percent of black mothers in Florida who placed their infant on their back to sleep from 56.4 percent (2014) to 58.4 percent.

Strategies

1a. Advance safe sleep behaviors among families and infant caregivers with an emphasis on disparate populations.

1b. Conduct a safe sleep survey of pediatricians, family practice physicians, pediatric nurse practitioners, birthing hospitals, and other medical providers practicing and/or located in Florida that provide services to pregnant women, postpartum women, and infants.

1c. Develop an evaluation plan for the implementation of the safe sleep survey.

2a. Implement a statewide Safe Sleep Certification model in birthing hospitals located in Florida.

2b. Using the Florida Healthy Babies Initiative, inventory and evaluate safe sleep activities currently implemented statewide.

2c. Partner with national organizations, such as the National Institute of Child Health Quality, to promote safe sleep initiatives and support local service providers (e.g. hospitals and social services) that interact with high risk populations.

ESMs	Status
ESM 5.1 - The number of birthing hospitals that are Safe Sleep Certified	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Child Health

State Action Plan Table (Florida) - Child Health - Entry 1	
Priority Need	
Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.	
NPM	
NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	
Objectives	
1. By December 31, 2021, increase the number of schools ever achieving the Healthier US Schools Challenge award from 507 (2016) to 800.	
2. By December 31, 2021, increase the percentage of Florida's population within one mile of bike lane and/or shared use paths from 42 percent (2017) to 45 percent.	
3. By June 30, 2019, increase the number of Florida counties where registered school nurses are implementing Healthy Lifestyle Interventions (5210-based) from seven to 15.	
4. By June 30, 2019, increase the percentage of body mass index (BMI) intervention screening referrals for students at or above the 95th percentile that results in students receiving services from a healthcare provider from 31.6 percent (2016-17 baseline) to 36.6 percent. (This measure is the sum of completed referrals to healthcare providers and completed Healthy Lifestyle interventions by registered school nurses.)	
5. Increase by 10 percent the number of Florida counties (school districts) that apply for recognition as a Florida Healthy District for the 2019-21 period compared to the number of districts that applied for the 2018-20 period.	
Strategies	
1. Promote/educate county school health programs about the use of the Healthy Lifestyle Intervention Individualized Healthcare Plan and coding this service data in the Department's Health Management System. Promote the Intervention on at least one School Health Services Program statewide conference call and during county School Health Program on-site monitoring meetings conducted by school health liaisons during the 2018–19 school year.	
2. Promote/educate county school health programs on the requirements, application process, and benefits of becoming a Florida Healthy District on at least one School Health Services Program statewide conference call and during county school program onsite monitoring meetings conducted by school health liaisons during the 2018–19 school year.	
3. Continue School Health Services Program involvement in the Florida Partnership for Healthy Schools (formerly the Florida Coordinated School Health Partnership), the Healthy District Collaborative, and the Interagency Collaborative by participating in meetings, conferences, and strategic planning.	
4. Promote the Center for Disease Control and Prevention's Whole School, Whole Community, Whole Child approach by educating county school health programs on strategies to expand school health advisory committee representation, including student/parent involvement, on at least one School Health Services Program statewide conference call and during county school health program on-site monitoring meetings conducted by school health liaisons during the 2018–19 school year.	
5. Promote policy, systems, and environmental approaches to increasing physical activity opportunities within the built environment for Floridians of all ages through coordination with local governments and stakeholders such as the Florida Department of Transportation, the Florida Recreation and Parks Association, East Central Florida Regional Planning Council, the Florida Department of Agriculture and Consumer Services, the Florida Department of Education and Florida Action for Healthy Kids.	
ESMs	Status
ESM 8.1.1 - The cumulative total of Florida school districts that have ever been awarded the evidence-based Florida Healthy School District recognition.	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

State Action Plan Table (Florida) - Child Health - Entry 2

Priority Need

Improve dental care access for children and pregnant women.

Objectives

1. By June 30, 2019 increase the number of low-income children under age 21 receiving a preventive dental service from a school-based sealant program from 94,000 children (SFY 2016-2017) to 98,700 children, an increase of 5 percent.

2. By September 30, 2019, increase the number of school-based sealant programs (internal or external) completing annual reports in FLOSS from 58 programs (SFY 2016-2017) to 61 programs.

3. By June 30, 2019, increase the number of schools reached by school-based sealant programs (internal or external) from 784 schools (SFY 2016-2017) to 823 schools, an increase of 5 percent.

Strategies

1. Partner with community agencies and organizations to improve data completeness related to statewide school-based sealant program efforts. Encourage participation in the FLOSS database and offer technical assistance as needed.

2. Increase the number of children participating in existing school-based sealant programs by implementing proven strategies to increase consent rate, such as educating parents, attending community events, and routine distribution of forms.

3. Improve the quality and sustainability of existing CHD school-based sealant programs by providing continued technical assistance and training and in-person site visits and program evaluations related to financial sustainability as requested.

State Action Plan Table (Florida) - Child Health - Entry 3

Priority Need

Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.

Objectives

1. By December 31, 2021, increase the number of partners and local county health departments participating in the Reach Out and Read program from 100 in 2017 to 120 total sites.

2. By December 31, 2021, increase the number of books distributed to parents and children through the Ounce of Prevention Fund of Florida from 26,612 in 2017 to 31,900 in 2021.

Strategies

1. Partner with local health departments in their childhood immunization, dental clinics, and well-child visits to encourage reading using the Reach Out and Read model, where a health professional distributes books to children at a well-child visit and emphasizes key reading strategies to parents (example: the importance of reading aloud to a child daily).

Adolescent Health

State Action Plan Table (Florida) - Adolescent Health - Entry 1	
Priority Need	
Promote activities to improve the health of children and adolescents and promote participation in extracurricular and/or out-of-school activities in a safe and healthy environment.	
NPM	
NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others	
Objectives	
1. By September 30, 2019, decrease the number of Florida high school students who experienced bullying on school property from 14.3 percent (2017) to 13 percent (2019).	
2. By September 30, 2019, decrease the number of Florida high school students who experienced electronic bullying in the past 12 months from 11.5 percent (2017) to 10 percent (2019).	
3. By September 30, 2019, increase the number of youth participating in positive youth development programs from 12,300 in 2017 to 12,700.	
Strategies	
1a. Partner with community agencies and organizations to promote bullying prevention initiatives.	
1b. Coordinate with the Department of Education's Safe Schools Program to integrate additional anti-bullying and violence prevention messages.	
2. Increase the number of youth with access to resources and hotlines related to violence and bullying prevention.	
3a. Promote the use of evidence-based curriculums.	
3b. Ensure that youth are receiving STD/HIV information and sexual risk avoidance strategies.	
3c. Provide positive youth development education to encourage healthy behaviors and the reduction of risky behaviors.	
ESMs	**Status**
ESM 9.1 - The number of students who participate in an evidence-based program that promotes positive youth development and non-violence intervention skills	Active
NOMs	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

Children with Special Health Care Needs

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 1
Priority Need
Increase access to medical homes and primary care for children with special health care needs.
NPM
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Objectives
1. By September 30, 2019, increase the number of pediatric providers in Florida identified as having a certified, recognized and/or accredited patient-centered medical home model by 5 percent.
2. By September 30, 2019, document the baseline of family satisfaction with access to care in a patient-centered medical home and primary care setting as evidenced by survey results.
3. By September 30, 2019, 100 percent of CMS Title V staff receive patient-centered medical home education and training annually as evidenced by electronic reporting systems.
Strategies
1a. Assess number and type of current patient-centered medical homes.
1b. Provide education, resources, and technical assistance to primary care providers for practice transformation towards patient-centered medical homeness.
2a. Assess family satisfaction with access to PCMH. Provide feedback, education, and technical assistance to practice for quality improvement initiatives.
2b. Create online repository for recognized PCMHs for families to be able to access.
3. CMS Title V staff will receive patient-centered medical home training during orientation and annually with completion documented through an electronic reporting system.

ESMs	Status
ESM 11.1 - Number of DOH team members, providers (pediatric, family practice, and adult), families, family partners, and other partners serving CYSHCN in Florida receiving education or technical assistance about the patient-centered medical home model and relat	Active
ESM 11.2 - Percentage of caregivers of CYSHCN in Florida who perceive themselves as a partner in their child's care.	Active
ESM 11.3 - Percentage of providers in underserved geographic areas that received formal technical assistance through the UCF HealthARCH program that became designated patient-centered medical homes.	Active
ESM 11.4 - Number of Adult Care Providers/Practices that report accepting CYSHCN transitioning to adult care.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 2

Priority Need

Improve health care transition to all aspects of adult life for adolescents and young adults with special health care needs.

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

1. By September 30, 2019, 100 percent of CMS Title V staff will receive transition-specific education and training annually as evidenced by electronic reporting systems.

2. By September 30, 2019, increase by 10 percent the number of providers who receive transition-specific education, training, and resources as evidenced by verbal, written, and/or electronic reporting.

3. By September 30, 2019, document the baseline number of educators who receive transition- education, training, and resources as evidenced by electronic reporting systems for baseline assessment.

4. By September 30, 2019, document percentage of children and families who accessed Department sponsored transition-education websites as evidenced by electronic reporting systems.

5. By September 30, 2019, 75 percent youth and families with special health care needs will report having access to community-based resources necessary to facilitate and achieve successful health care transition when surveyed.

6. By September 30, 2019, increase youth with special health care needs voice in transition program activities as evidenced by a 5 percent increase in the type and number of youth-led health and education transition-specific activities.

Strategies

1. CMS Title V staff will receive transition education during orientation and annually with completion documented through an electronic reporting system.

2. Providers are provided with transition education, training, and resources. Promote the six core elements of health care transition per national guidelines.

3. Educators are provided with transition education, training, and resources.

4. Assess, develop, monitor, improve quality, and promote public access to transition-specific, age-appropriate education materials to support the aspects of health, work/school, self-determination, and self-management for children with special health care needs.

5. Assess, develop, monitor, improve quality, and promote community-based resources and other supports necessary to facilitate and achieve successful health care transition for patients and families with special health care needs.

6. Promote growth in the youth voice and program involvement at the community, state, and national level for health and education transition-specific activities.

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 3

Priority Need

Improve access to appropriate mental health services to all children.

Objectives

1. By September 30, 2019, 100 percent of CMS Title V staff receive education and training on issues related to pediatric behavioral health annually as evidenced by electronic reporting systems.

2. By September 30, 2019, increase by 5 percent the number of primary care and specialty care providers who receive pediatric behavioral health education and training as evidenced by manual and electronic reporting systems.

3. By September 30, 2019, increase by 5 percent the number of providers who were provided or accessed electronically behavioral health resources as evidenced by manual and electronic reporting systems.

4. By September 30, 2019, determine the percentage of children and families who were provided or accessed electronically behavioral health education materials or resources as evidenced by manual and electronic reporting systems.

5. By September 30, 2019, determine collaboration efforts with primary care and behavioral health partners at local, state and national level as evidenced by meeting attendance, type of activities, memorandum of agreements/understandings and contracts and the Wilder Collaboration Factors Inventory.

Strategies

1. CMS Title V staff will receive behavioral health education during orientation and annually with completion documented through an electronic reporting system.

2. Providers will be offered opportunities for education/training for pediatric behavioral health care diagnosis including infant mental health, autism spectrum disorder and other emerging topics identified

3. Providers are equipped with resources to help improve access to behavioral health care.

4. Provide children and families with educational and other resources (i.e. parent based screening tools, resources, websites, directories) to promote access to behavioral health services.

5. Build system of care capacity for behavioral health services statewide with stakeholders at the local, state, and national level. Promote evidenced based strategies such as integrated care. Pilot behavioral health implementation projects. Evaluate Results. Build Sustainability. Replicate efforts that show promising practices.

State Action Plan Table (Florida) - Children with Special Health Care Needs - Entry 4

Priority Need

Increase access to medical homes and primary care for children with special health care needs.

Objectives

1. By September 30, 2019, 100 percent of CMS Title V staff will receive workforce development training as evidenced by electronic and manual reporting systems.

2. By September 30, 2019, 85 percent of CMS Title V staff will report having an increase in public health knowledge and skill set as a result of participating in workforce development trainings as evidenced by electronic and manual self-reporting surveys.

Strategies

1a. CMS Central Office will convene a statewide workgroup to strategically plan the development of the workforce training.

1b. CMS Title V staff will complete needs assessment surveying what type of training they feel they need to transition from direct care services to public health services.

1c. CMS will partner with the National Maternal Child Health Workforce Development Center or other national stakeholder for assistance in the planning, development, and implementation of the workforce training.

1d. CMS will implement workforce development utilizing various adult learning methods in a variety of venues including: face-to-face, webinars, coaching calls, etc.

2a. CMS leadership will develop specific skill building modules in change management/adaptive leadership, systems integration and evidenced-based decision making,

2b. CMS leadership will evaluate staff perception of increased public health knowledge and skill set after each training session.

2c. CMS leadership will analyze the results of each training session and utilizing the continuous quality improvement planning cycle for future training needs.

2d. CMS leadership will develop additional trainings as workforce needs are identified.